**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
John C Milani MD

**Respondent Name**
Poly America LP

**MFDR Tracking Number**
M4-13-2968-01

**Carrier's Austin Representative**
Box Number 11

**MFDR Date Received**
July 10, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "When we preauthorized this surgery, we noted the surgery date as 2/25/2013 as well on the documentation of the paperwork we noted (emergency case). We are attaching a copy of Dr Milani's office visit notes when we saw the patient on February 22. You will note under the history of the patient the details of the current problems which necessitated the surgery to become an emergency."

**Amount in Dispute:** $4,066.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute received however, no position statement submitted.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 25, 2013 | 63047 – AS | $4,066.00 | $1,737.70 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines medical emergency.
3. 28 Texas Administrative Code §134.600 sets our guidelines for prospective and concurrent review of health care
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of, or exceeded, pre-certification and/or authorization.
   - 193 – Original payment decision is being maintained

**Issues**

1. Are the disputed services subject to prior authorization?

2. Did the carrier authorize based on medical necessity?
3. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied the services in dispute as, 197 – "Precertification/authorization absent". Per 133.2(5) states, "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (I) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part;

   Review of the submitted documentation finds;

   - History and Physical - The studies include MRI. The MRI was performed on 02/18/2013 and was consistent with a very large 9mm central and left paracentral disc herniation at L5S1. This obliterates the canal, producing severs canal stenosis and thecal sac and nerve root impingement. There is also a large left paracentral inferiorly herniated, inferior disc extrusion, which obliterates the thecal sac at S1. There is left greater than right nerve root impingement. There is a central 4mm protrusion with annular tear greater on the left at L4-5. There is canal stenosis to 9mm and bilateral lateral recess and neural foraminal narrowing greater on the left."
   - Operative Report – "The large extruded fragment from the left lateral recess and central canal was able to be retrieved."

   The Division finds the submitted documentation supports without treatment, serious dysfunction of the injured area could be reasonably expected. The carrier's denial is not supported.

2. Per 28 Texas Administrative Code 134.600(c)(1)(A) states in pertinent part, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title,…" The definition of emergency has been met and the procedure was deemed medically necessary as supported by Certification of Medstar Medical Management. Therefore, the disputed services will be reviewed per applicable fee guidelines.

3. Per 28 Texas Administrative Code 134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." Medlearn Matters Article, 6123, (www.cms.hhs.gov) states, "The payment amount for a PA, NP, or CNS assisting at surgery is calculated as follows: The facility specific MPFS amount ***multiplied by*** a 16 percent assistant at surgery reduction amount ***multiplied by*** an 85 percent non-physician practitioner reduction ***minus*** the deductible and coinsurance, ***and then multiplied by*** times 115 percent,

   **OR**

   **((MPFS X .16 X .85) – (deductible and coinsurance)) X 1.15)**". The Medicare Physician Fee Schedule amount is $1,106.74 x.16 = 929.66 x 1.15 = $1,069.11. The Maximum Allowable Reimbursement (MAR) = (TDI-DWC Conversion Factor / Medicare Conversion Factor) x Medicare Price or (55.3 / 34.023) x $1,069.11 = $1,737.70. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,737.70.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,737.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | June 5, 2014<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.